| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210a)<br>300.1210b)<br>300.1220b)3<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the | S9999 | Attachment A<br>Statement of Licensure Violations | |

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nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Requirements are not met as evidenced by:

Based on observation, interviews and record review the facility failed to ensure that a resident who has a diagnosis of dysphagia and had an order to eat in small bites was monitored during meal. The facility also failed to consistently monitor and document the activities for a resident who was identified to be needing every 15 minutes monitoring due to inappropriate behavior. This applies to 1 of 3 residents (R1) reviewed for aspiration precaution and 1 of 3 residents (R5) reviewed for behavior.
This failure resulted in R1 being found unresponsive with a meat lodged in the airway by the emergency medical personnel on August 23, 2015. R1 expired at the hospital with the cause of death of anoxic encephalopathy due to aspiration of food bolus.

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The findings include:
1. R1 was originally admitted to the facility on March 3, 2014 with multiple diagnoses which included dementia with behavior disturbance, pseudobulbar affect, schizoaffective disorder, bipolar disorder, chronic venous embolism & thrombosis of deep vessels, hypertension and asthma based on the face sheet. R1's speech therapy plan of care dated January 29, 2015 showed that the resident has a diagnosis of dysphagia (difficulty swallowing), oropharyngeal phase.
The facility's initial incident report dated August 23, 2015 (7:38 PM, time of incident) showed that R1 was found unresponsive, CPR (cardio pulmonary resuscitation) was initiated, 911 was called and R1 was transferred to the hospital emergency room. R1's physician and family were notified.
R1's progress notes dated August 23, 2015 (7:40 PM) showed an incidental note, "Notified by CNA (certified nursing assistant) that res. (resident) was not responsive. Found res. in room in w/c (wheelchair)- not responsive- no pulse, resp. (respiration), or b/p (blood pressure). Did finger sweep-nothing felt in mouth. Began CPR. Called 911. 911 arrived & with light & forceps found food lodged deep in res. throat. Removed food. Ambulance left with res. for hospital. Still doing mechanical ventilation."
The fire department report dated August 23, 2015 showed that the dispatch was notified at 7:36 PM and that the fire department emergency personnel arrived at the resident at 7:42 PM. The fire department report showed that when the crew arrived at the scene, R1 was unconscious. "CPR initiated, staff members of facility stated it was "maybe a 5 minute downtime." IV (intravenous) established in the jugular. Pt. (patient) had a golf ball size hunk of meat lodged

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in her airway, after removal Pt. was intubated and Epi (epinephrine) was pushed." R1 was transferred to the hospital emergency room.
R1's quarterly MDS (minimum data set) dated August 20, 2015 showed a BIMS (Brief Interview for Mental Status) score of "11" showing that the resident is moderately impaired with cognition.
The same MDS showed that R1 required limited assistance x 1 person physical assist with most of ADL's (activities of daily living) including eating.
R1's physician signed POS (physician order sheet) dated August 15 through September 14, 2015 showed orders for, general diet, regular liquids, small bites, up right at 90 degrees, no added salt, double portions, double meat at dinner and milk with all meals.
R1's diet care plan initiated on May 27, 2015 does not address the resident's swallowing problem (dysphagia). R1 ' s diet care plan also does not address the physician's order for small bites.
The facility's dinner menu for August 23, 2015 was Bratwurst sausage, hot dog bun, buttered green peas and fruited gelatin.
R1's dietary flow sheet for the month of August 2015 showed that on August 23, 2015, the resident ate 100% of the food served at dinner.
In an interview held on September 1, 2015 at 1:20 PM, E12 (dietary supervisor) stated that on August 23, 2015, R1's meal tray ticket indicated a diet of regular, no added salt. E12 showed R1's meal tray ticket that was in place on August 23, 2015. The meal tray ticket showed that R1 was served regular, no added salt diet, double meat at supper. The same meal tray ticket showed on the bottom, "To tuck chin at all meals, small bites/sips, slow rate of intake, upright 90 degrees. Aspiration precautions."
In a phone interview held on September 1, 2015 at 3:15 PM, E8 (CNA) stated that she worked on August 23, 2015 during the 3PM - 11PM shift.

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Per E8, she was not the assigned CNA for R1. E8 stated that she saw R1 sitting at the dining table waiting for dinner to be served, but did not actually see R1 eat or what food the resident had for dinner on August 23, 2015.
In a phone interview held on September 2, 2015 at 2:00 PM, E9 (CNA) stated that she worked on August 23, 2015 during the 3PM - 11PM shift, but was not the assigned CNA for R1. E9 stated that she was near the table where R1 and 6 other residents were eating, during dinner on August 23, 2015. Per E9, R1 was served two Bratwurst sausage sandwiches for dinner on August 23, 2015 but, E9 does not know how the Bratwurst sandwiches were served to R1. E9 stated that she does not know if R1's Bratwurst sandwiches were cut into small bites or not. Per E9, she saw R1 holding the Bratwurst sandwich and biting into it. R1 finished the 2 Bratwurst sausage sandwiches.
In a phone interview held on September 2, 2015 at 10:30 AM, E7 (CNA) stated that she was the assigned staff for R1 on August 23, 2015. Per E7 she was the meal monitor assigned to R1's table. R1 was served two whole Bratwurst sandwiches and she saw R1 biting into it. R1 ate all the two Bratwurst sandwiches and all the rest of the food that were served for dinner on August 23, 2015. Per E7, on August 23, 2015 she saw R1 ate the dinner meal but she was not at the same table with R1 to make sure that R1 eat in small bites. E7 stated that after dinner, R1 asked her for an incontinent brief, before R1 wheeled self from the dining room to the room. Per E7, while R1 was leaving the dining area, she did not see R1 pick up any food from any meal tray in the dining room. E7 added that, when the paramedics came to respond on August 23, 2015, she saw the paramedics pulled out a meat from R1's throat. E7 described the meat to be

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approximately half to an inch long, round in shape like a sausage.
In a phone interview held on September 2, 2015 at 1:10 PM, Z1 (primary physician) stated that R1 has diagnoses of dementia and dysphagia. Per Z1, R1 was able to cut the food. However, since there was an order for R1 to eat the meals in small bites, he expected the facility staff to make sure that they monitor and oversee that R1 eat in small bites at all times. Z1 stated that he saw R1 at the hospital intensive care unit on August 24, 2015 (day after the incident). R1 did not recover from being unresponsive and was declared brain dead. Z1 stated that because of no activity to R1's brain, the family decided to let go.
The Coroner's death investigation report showed that R1 died on August 24, 2015 at the hospital. R1's cause of death was, anoxic encephalopathy, due to or as a consequence of aspiration of food bolus.
On 9/3/15 at 10:25 AM R4 stated the following: About 2 weeks ago (R4 was unable to recall exact date of the incident) R5 exposed himself to her (R4). R5 touched R4 in her right thigh and her hair. R5 always say something sexual to her like saying "R5 is gonna stick to me." R4 also sneaks in other wings and/or other bedrooms of female peers. R4 reported it to the staff and it seems like nothing is being followed up.

Interviews of other residents were on 9/3/15 from 11:20 AM to 12:20 PM. R8, R9, R10, R11 and R12.

At 11:20 AM R8 stated: R5 goes to other people's (residents') room. R5 follows female residents including her (R8) and say inappropriate things to them. R8 added "Yes, I'm uncomfortable with R5. He (R5) is intimidating."

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At 11:25 AM R9 stated, "Yes, R5 does follow women around. When I came here the first time, R5 introduced himself and held his hand out then R5 pulled me. R5 did it twice to me.

At 11:30 AM R10 stated: "R5 follows me around, R5 touches me in the arm and elbow. One time he (R5) grabbed my breast. Yes he goes to other people's room."

At 11:40 AM R11 stated: "R5 follows me (R11) around, whispering inappropriate words like "Let's get together" R5 already touched me twice today. I didn't tell anyone because I feel that it's too petty. R5 makes me uncomfortable."

At 12:20 PM R12 stated: "R5 had touched me in my breast and my butt. R5 touched me twice. R5 makes me uncomfortable. R5 follows me around sometimes."

On 9/3/15 at 12:10 PM, E18 PRSC stated the following: E18 received complaints about R5 with regards to his sexual inappropriateness. Sometimes R5 has delusions that some of the women in the facility has had relationship with R5 in the past. E18 witnessed R5 staring at women and attempting to sneak in their wing. All staff watched R5 and when E18 is in the day area E18 also watched R5. R5 is on a 1:1 close monitoring every 15 minutes as part of the facility's interventions due to his behavior. R5 has been on 1:1 monitoring since April, 2015.

After the interview, E18 left his office, came back at around 12:25 PM and presented a copy of 1:1 monitoring every 15 minutes for the month of August. When asked about the monitoring sheets from April to present, E18 later said (which is one and a half hour later around 2PM) he made a

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mistake with his statement, the 1:1 monitoring started in June 2015 not April. E18 then presented copies of monitoring sheets, which E18 said was from June to September 2015. However, the monitoring sheets which E18 claimed were for month of June 2015 and September 2015 has no resident's name, no date, no staff signature and no reasons for monitoring.

R5 has been observed in the day area/dining room on 9/3/15 from 11:15 AM to 12:10 PM roaming around without a staff supervision or monitoring him on a 1:1 basis. At 12:30 PM after interviewing E18 in his office, R5 was noted being monitored 1:1 by E20 (CNA/Certified Nursing Assistant). E20 does not have a monitoring sheet with her and at 1:10 PM E20 stated she just took over the monitoring from E21 (CNA), she will log all activities and whereabouts of R5 at the end of the shift. When E20 was asked if she would be able to tell surveyor the exact time, whereabouts and activities of R5's every 15 minutes since she started monitoring him (R5), E20 responded she's not sure. E20 added yes, she should have the monitoring log with her.

On 9/3/15 at 1:15 PM E21 (CNA) stated, E21 monitored R5 on a 1:1 basis from 10:30 AM to 11 AM, then she turned it over to E20. Since the E20 has been monitoring R5 as far as she (E21) knows. When asked to present the copy of her monitoring log for R5, E21 stated she had not log it in yet.

( A)

**IMPOSED PLAN OF CORRECTION**

Attachment B
Imposed Plan of Correction

NAME OF FACILITY: Frankfort Terrace Nursing Center
DATE AND TYPE OF SURVEY: September 18, 2015 Complaint

300.1210a)
300.1210b)
300.1220b)3
300.3240a)

300.1210a) General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

300.1210b) d Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis

300.1220b)3 The DON shall supervise and oversee the nursing services of the facility, including: Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This will be accomplished by:

I. A committee consisting of at a minimum, the Medical Director, Administrator and Director of Nursing (DON) will review and revise the policies and procedures for staff regarding abuse and neglect. This review will ensure that the facility's policies and procedures address at a minimum the following:

A. Recognition of situations that could be interpreted as abusive or neglectful.
B. Appropriate reporting of staff.
C. Appropriate and thorough investigations to prevent further potential abuse while investigation in progress.
E. The facility taking appropriate corrective action when an alleged violation is verified.
F. Maintaining and updating care plans with new interventions.

II. The facility will conduct mandatory in services for all staff within 30 days that addresses at a minimum the following:

A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this plan of correction.
B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
C. Documentation of theses in-services will include the names of those attending, topics covered, location, day and time. This documentation will be maintained in the administrator's office.

III. The following action will be taken to prevent re-occurrence:

A. The above in-service education will be reviewed with all staff on a regular basis.
B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow up) are followed.

IV. The Administrator and Director of Nursing will monitor items I through III to ensure compliance with this imposed plan of correction

Date of completion: 10 days from receipt of the Imposed Plan of Correction

JP 10/22/2015

Attachment B
Imposed Plan of Correction